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ABSTRACT

Clients' causal explanations for their psychological difficulties have received significant notice in the research literature. In contrast, few studies have focused on the attributions formulated by counselors regarding their clients' difficulties. Attributional approaches to counseling suggest that both client and counselor attributions can affect the course of counseling. This study investigated the relationships between counselor attributions for client presentations and counselor intervention choice. Intake counselors (N=15) were asked to formulate attributions for client presenting problems, and then to choose an ideal treatment intervention. Clients evaluated for the study were students (N=113) who presented for counseling at a large university counseling center. Results suggest that the attributional dimensions of controllability, stability, and globality were related to intervention choice. These findings raise the question about the possible relationships between counselor and counselor attributions for client problems. A second issue concerns the counselor expectations that might be generated by the treatment assignment made for a client. (Author/ABL)

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# Relationships Between Counselor Attribution and Intervention Choice

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Abstract

Attributional approaches to counseling suggest that both client and counselor attributions can affect the course of counseling. The present study investigated the relationships between counselor attributions for client presentations and counselor intervention choice. Intake counselors were asked to formulate attributions for client presenting problems, and then to choose an ideal treatment intervention. Results suggested that the attributional dimensions of controllability, stability and globality were related to intervention choice.

Relationships Between Counselor Attribution and Intervention Choice

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Client's causal explanations for their psychological difficulties have received significant notice in the research literature (Abramson, Seligman & Teasdale, 1987; Claiborn & Dowd, 1985; Forsyth & Forsyth, 1982; Green & Altmaier, 1986; Hoffman & Teglasi, 1982). In contrast, few studies have focused on the attributions formulated by counselors regarding their clients' difficulties. The small amount of research which has examined counselor attributions has produced mixed results. Strohmer and his associates (Strohmer, Haase, Biggs & Keller, 1982; Haase, Strohmer, Biggs & Keller, 1983; Strohmer, Biggs, Keller & Thibodeau, 1984) investigated the role of attributions in clinical judgments in a series of studies. Their results indicated that attributional dimensions did not play a significant role in clinical judgments except when the task involved diagnostic discriminations between bipolar vs. unipolar disorders. However, controllability of causal factors was the sole attributional dimension Strohmer et al. assessed. Other causal dimensions--for example, internality, stability, and globality (Abramson, Seligman, & Teasdale, 1978)--have been identified and would seem to warrant consideration in investigations of the clinical judgment process.

One other study has focused on attributional information as it relates to counselor treatment assignment. Batson (1975) compared professional and nonprofessional helpers' responses to clients who

presented problems attributed to situational factors. Broad categories of treatment options, ranging from institutions oriented towards changing the individual (e.g., mental hospital, residential treatment center) to those oriented toward changing the individual's social situation (e.g., social services or employment agency) were presented as choices. Batson noted an overall tendency to attribute client problems to personal factors and found that treatment referrals tended to match the attributions formulated. In sum, clients whose problems were attributed to personal factors were more likely to be referred to agencies concerned with personal change; whereas when the problem was seen as situational, clients were more often referred to social change agencies.

Conceivably, attributions concerning the source of a client's difficulties could influence the type of treatment deemed appropriate for a client, since counselors may implicitly link causal hypotheses to treatment prognosis. Several counselor attributions may lead to an assignment to long-term, more intensive forms of treatment. For example, if the counselor perceives the client's presenting problem as not being within the client's immediate control (e.g., a severe personality disorder), the client may be assigned to long-term counseling. Similarly, attributions to causes which are internal to the client, stable across time, or pervade many areas of the client's life, may also lead to assignment to long-term, as opposed to short-term treatment. On the other hand, if the client's problem is attributed to external,

controllable, specific, and/or unstable causes, an assignment to short-term or group counseling may be more likely.

The present study attempted to directly assess the relationships between counselor causal inference and assignment to treatment modalities within one agency. Following a standard intake interview, counselors in a university counseling center were asked to rate client problems along several attributional dimensions derived from Weiner's (1979) model of outcome attribution. The counselors were also asked to indicate the ideal treatment modality for the client in question. It was expected that certain attributions (internal, uncontrollable, stable over time, global) would be associated with an assignment to the most intensive form of intervention offered by the center, long term individual counseling. Conversely, it was predicted that when the source of the client's problems was located in causes that were external, controllable, unstable, or specific, an assignment to brief (3 sessions) counseling would be more likely. The problems of clients assigned to intermediate modes of treatment, such as short-term counseling (i.e., falling between brief and long-term approaches) or counseling groups were expected to fall between those of the other groups on the attributional dimensions.

## Method

Participants. Fifteen counselors participated in the study on a voluntary basis, nine females and six males. Counselors ranged in experience level from advanced graduate students to professionals with over 20 years of counseling experience. Two clinical psychologists, two

clinical social workers, and 11 counseling psychologists participated in the study.

Clients evaluated by the counselors in the study were 113 students who presented for counseling at a large university counseling center. Seventy three clients were female, 40 male.

Procedure. Following the completion of a one hour intake interview with a client, counselors were asked to rate the client's presenting problem along a number of attributional dimensions. Each of these items began with the stem: "To what degree is the client's problem caused by factors" and finished with a presentation, in nontechnical terms, of an attributional dimension. The item was followed by a 7 point Lickert-type scale. Four major attributional dimensions were assessed: controllability (1=controllable, 7=not at all controllable), internality (1=internal, 7=external), stability (1=enduring, 7=transient), and globality (1=specific to the situation, 7=pervasive across situations). After completing the attributional items, counselors were asked to specify their first choice of treatment for the client. Five options were presented, corresponding to the treatment modalities currently being offered at the center: a) brief counseling (1 to 3 sessions), b) short-term counseling (4 to 10 sessions), c) long-term counseling (10 or more sessions), d) group counseling (unlimited number of sessions), and e) no treatment. Counselors also rated the severity of the client's presenting problem on a scale which ranged from 1 (mild) to 5 (crisis).

## Results

Responses to the attributional items were submitted to a series of multivariate analyses of variance (MANOVAs) which crossed treatment category and other variables of interest. All analyses corrected for the nonorthogonality introduced by unequal numbers of subjects in treatment categories. Analyses that crossed sex of client, sex of therapist, and therapists with treatment revealed significant main effects for treatment, but no main effects for the additional variables were detected. The interactions of the demographic variables with treatment categories were also nonsignificant. (Fs for all preliminary analyses are available upon request). Severity ratings were dichotomized and crossed with treatment in yet another MONOVA, which also yielded nonsignificant results. Therefore, the data were collapsed across these dimensions.

Data from the attributional items were submitted to a one-way MONOVA by treatment assignments. Incomplete protocols were received for four clients; these data were therefore excluded from the analyses, reducing the total client N to 112. Using Pillai's Trace as an approximation of F, a significant effect of treatment group was documented, $F(16,248) = 2.87$, $p$ .002. Univariate analyses revealed significant differences among treatment assignments were found for three of the four attributional dimensions: controllability ($F(4,108) = 3.48$, $p$ .01), stability ($F(4,108 = 62.63$, $p$ .001), and globality ($F(4,107) = 3.68$ $p$ .01). The analysis for internality was nonsignificant, $F(4,111) = .63$, $p$ .05.

Table 1 presents the means for these variables.

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Insert Table 1 about here

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Post hoc tests conducted using Duncan's Multiple Range Test indicated that for the controllability dimension, the presenting problems of clients assigned to no treatment were seen as significantly more controllable than those of clients assigned to short- or long-term counseling (M = 2.2 for the no treatment group, Ms = 4.1 and 3.4 for the long-term and short-term groups). Attributions for the problems of clients assigned to brief counseling and group did not differ from any of the other treatment groups (Ms = 3.0 and 3.2 for the brief counseling and group counseling clients). Clients assigned to brief counseling or no treatment were seen as having problems which were significantly less stable than the other treatment groups (Ms = 5.3 and 5.2 for the brief and no treatment groups, 3.8, 3.0 and 3.4 for the short-term, long-term and group categories). Problem attributions for clients assigned to group counseling, long-term and short-term counseling did not differ on the stability dimension. Finally, clients assigned to no treatment presented problems judged to be significantly less global (i.e., more specific) than the problems of clients assigned to long-term, short-term or group counseling (Ms = 2.2 for the no treatment group, Ms = 4.3, 3.6, and 4.2 for the long-term, short-term, and group categories). The mean

for the brief counseling group (M = 3.1) did not differ significantly from any of the groups.

## Discussion

The results of the present study suggested that counselors' attributions concerning client problems were related to the type of treatment to which a client was assigned. In general, the presenting problems of clients assigned no treatment were seen as more controllable, less stable and more situationally specific than those of the clients assigned to other treatment options. In contrast, problems of clients assigned to short- or long-term treatment were apparently perceived as not under the client's control, more stable over time, and more pervasive within the clients' lives. The issues presented by clients assigned to brief and group counseling tended not to differ in terms of counselor attributional judgments from the other treatment groups.

Counselors demonstrated a consistent tendency to perceive the problems of clients assigned to any form of counseling as being uncontrollable, stable, and global to some degree. However, it is important to note that even for the long-term counseling clients, the means for these dimensions fell between 4 and 5 on the 7-point scale provided. Therefore, while counselors clearly saw these client problems differently than those of clients assigned no treatment, they seemed to also be indicating that clients had some control over causal factors, that causes were not uniformly pervasive, and that causal factors might be somewhat unstable in nature. These findings indicate that counselors

do not rigidly assign client problems to the extreme categories of causal factors; instead, they appear to conceptualize client situations as changable to one degree or another.

The attributional dimension of internality showed no significant differences between treatment groups, contrary to what was expected based upon Batson's (1975) findings. Instead, counselors seemed to reserve judgment on this dimension--the overall mean for this item was 3.62, falling almost exactly in the middle of the scale. Alternatively, counselors could be using the extremes of this scale in a manner that covaried with variables other than those investigated in the present study. More research is needed to determine if these or other explanations are viable, since this attributional dimension has proven to be influential in previous research (e.g., Forsyth & Forsyth, 1982; Weiner, 1979).

These findings yield significant information about the clinical judgment process, and also raise further questions about other issues related to counseling process and outcome. The most basic question raised by the findings of the present study involves the possible relationships between counselor and client attributions for client problems. If the client and counselor agree on the causal factors involved in the presenting problems, a productive therapeutic relationship is likely to result (Strong & Claiborn, 1982). However, if the two individuals disagree, the counseling relationship may be less than productive, or the client may even terminate prematurely. Given

that counselors seem to have a tendency to perceive client problems as uncontrollable, stable, and global, they may attempt directly, or indirectly, to alert the client to their perspectives. Winning the client over to the counselor's view could be either helpful or harmful. If the counselor, a socially powerful person (Strong, 1978), communicates to the client that his or her difficulties stem from causes that are uncontrollable, the client may adopt this inference and the potential for change may be undermined. The change process could be facilitated, conversely, if the client presents with the belief that her or his problem results from external causes, and is confronted with the counselor's attribution to internal causes. The new perspective offered by the counselor may enable the client to see the problem as one he or she can change.

A second issue raised by the results of the present study concerns the counselor expectations that might be generated by the treatment assignment made for a client. The counselor who eventually works with the client (whether the intake counselor or other) may be influenced by the treatment decision if he or she follows the attributional patterns suggested by the present data. For instance, if a counselor is assigned a client with the specific recommendation for long-term counseling, research in cognitive processing suggests she or he may begin counseling by seeking information which confirms the uncontrollable, stable and global nature of the client's difficulties (e.g., Hirsch & Stone, 1983; Snyder & Swann, 1978). Also, the receiving counselor may tend to

remember information which is consistent with the attributional categories more accurately than information which is inconsistent (Murdock, 1986). On the other hand, a counselor assigned a client for brief therapy may tend to ignore or forget information presented by the client suggesting that the problem is more stable, global, or uncontrollable than the brief assignment apparently reflects.

The present study provides some insight into the clinical judgment process of counselors. However, as with most research, these data generate more questions than answers. The possibilities raised above represent but a few of many directions suggested by taking an attributional approach to clinical judgment. Further investigation into these issues, as well as other questions generated by taking an attributional approach, is clearly warranted.

Table 1

Means for Attributional Dimensions

by Treatment Category

| Attribution | Treatment | | | | |
|---|---|---|---|---|---|
| | Brief | Short-Term | Long-Term | Group | NT |
| | (n = 13) | (n = 39) | (n = 30) | (n = 25) | (n = 5) |
| Controllability | $3.0^{ab}$ | $3.4^{a}$ | $4.1^{a}$ | $3.2^{ab}$ | $2.2^{b}$ |
| Stability | $5.3^{a}$ | $3.8^{b}$ | $3.0^{b}$ | $3.4^{b}$ | $5.2^{a}$ |
| Globality | $3.1^{ab}$ | $3.6^{a}$ | $4.3^{a}$ | $4.2^{a}$ | $2.2^{b}$ |

Note. Means with different letters differ at the .05 level of significance by Duncan's Multiple Range Test.

Codes: Controllability: 1=controllable, 7=uncontrollable; Stability: 1=stable, 7=unstable; Globality: 1=specific, 7=global

NT=no treatment

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